



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK--ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 14, 2016

Kenneth Shull, Administrator
Clearwater Health & Rehabilitation
1204 Shriver Road
Orofino, ID 83544-9033

Provider #: 135048

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr.. Shull:

On **December 5, 2016**, a Facility Fire Safety and Construction survey was conducted at **Clearwater Health & Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE**

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completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 27, 2016**. Failure to submit an acceptable PoC by **December 27, 2016**, may result in the imposition of civil monetary penalties by **January 16, 2017**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 9, 2017**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 9, 2017**. A change in the seriousness of the deficiencies on **January 9, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 9, 2017**, includes the following:

Denial of payment for new admissions effective **March 5, 2017**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 5, 2017**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 5, 2016**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 27, 2016**. If your request for informal dispute resolution is received after **December 27, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

A handwritten signature in black ink that reads "Nate Elkins" followed by a stylized monogram or initials.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2016
NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story type V (111) building with a small basement which includes a maintenance shop and boiler room. The facility is protected by a complete sprinkler system and was built in 1969. The fire alarm system was replaced in 2001. Currently the facility is licensed for 60 beds. The following deficiencies were cited during the annual life safety code survey conducted on December 5, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	This Plan of correction does not constitute an agreement by the provider of facts or conclusions set forth in this Statement of Deficiencies. The Plan of Correction is prepared solely because it is required by Federal and State law. RECEIVED DEC 28 2016 FACILITY STANDARDS	
K 161 SS=D	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered	K 161	K 161 What corrective action will be accomplished for those residents found to have been affected by this deficient practice; The twelve residents, staff and visitors on that hall had the potential of being affected by this deficient practice. Fire Barrier Water Tight Penetration Sealant 1000NS 3M was used to repair the penetration on 12/7/2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Summit S. Shull

ADMINISTRATOR

12/21/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 161	Continued From page 1	K 161	<p>How will you identify the other residents having the potential to be affected by this same deficient practice and what corrective actions will be taken;</p> <p>All residents, staff and visitors had the potential to be affected by this deficient practice. Maintenance Director or designee conducted an audit of all ceiling penetrations within the facility.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>Ceiling penetration audits will be added to the TEL system for quarterly review. Maintenance Director will report to the QA committee on an ongoing basis.</p>	
	<p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to ensure the smoke and fire resistive properties of the structure were maintained. Failure to maintain the fire resistive properties of the structure by sealing penetrations created by pipes passing into attic spaces, could result in fires and smoke passing between compartments during a fire. This deficient practice affected 12 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 5, 2016 from approximately 1:15 PM to 2:00 PM, observation of the ceiling in the interior of the</p>			

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K 161	Continued From page 2 oxygen storage, located between rooms 10 and 11, revealed an approximately three (3) inch diameter pipe which penetrated the ceiling. Further observation revealed an approximately 1/2 inch gap between the pipe and the ceiling which had not been sealed, exposing the attic space above. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.	K 161	How the corrective action will be monitored to ensure the deficient practice will not recur; Ceiling penetration audits will be added to the TEL system for quarterly review. Maintenance Director will report to the QA committee on an ongoing basis. Dates when corrective action will be completed; These corrective actions were completed on 12/7/2016.	12/7/16
K 200 SS=F	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This Standard is not met as evidenced by: Based on record review, the facility failed to	K 200	K 200 What corrective action will be accomplished for those residents who have been affected by the deficient practice; Twenty nine residents, staff and visitors had the potential to be affected by this deficient practice. The fire doors and assemblies have been inspected using NFPA 80.	

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K 200	<p>Continued From page 3</p> <p>ensure that fire rated assemblies were inspected in accordance with NFPA 80. Failure to inspect and test fire rated doors could result in a lack of system performance as designed. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During review of provided facility annual inspection records conducted on December 5, 2016 from approximately 9:00 AM to 10:00 AM, no record was available demonstrating any initial or annual inspection and testing indicating type and function of fire rated door assemblies had been conducted.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6</p>		K 200	<p>How will you identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents staff and visitors had the potential to be affected by this deficient practice. The fire doors and assemblies have been inspected using NFPA 80.</p> <p>What measures will be into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>The inspection of all fire doors and assemblies will be placed on the TEL system and will be inspected annually and be presented at QA on an ongoing basis. All NFPA 80 inspection requirements have been reviewed and understood by the Maintenance Director and Administrator.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur;</p> <p>The inspection of all fire doors and assemblies will be placed on the TEL system and will be inspected annually and be presented at QA on an ongoing basis.</p>	

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K 200	Continued From page 4 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.	K 200	Date when corrective action completed; These corrective actions were completed on 12/6/2016	12/6/16
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)	K 325	What corrective action will be accomplished for those residents found to have been affected by this deficient practice; This deficient practice had the potential to affect 32 residents, staff and visitors. Housekeeping Manager in-serviced her staff on how to conduct inspections of the ABHRs and has instituted an inspection log to be completed in accordance with manufacturer's recommendations. How will you identify other resident having the potential to be affected by the same deficient practice and what corrective actions will be taken; All residents, staff and visitors have the potential to be affected by this deficient practice. Housekeeping	

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K 325	<p>Continued From page 5</p> <p>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of automatic dispensing ABHR dispensers could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF residents and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the review of facility inspection records conducted on December 5, 2016 from approximately 9:00 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR dispensers was performed when refilling dispensers in accordance with manufacturer's care and use instructions.</p> <p>2) During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 3:30 PM, observation of installed ABHR dispensers revealed automatic dispensers had been installed in four of four smoke compartments. When asked about automatic ABHR dispenser refill testing and documentation, the Housekeeping Manager stated she was not aware that dispensers were required to be tested each time a refill was installed.</p> <p>Actual NFPA standard:</p>	K 325	<p>Manager in-serviced her staff on how to conduct inspections of the ABHRs and has instituted an inspection log to be completed in accordance with manufacturer's recommendations.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p>Housekeeping staff will conduct inspections of the AHBRs with every refill, per manufacturer's recommendations and Federal and State guidelines, and report to the QA Committee on an ongoing basis.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur;</p> <p>Housekeeping staff will conduct inspections of the AHBRs with every refill, per manufacturer's recommendations and Federal and State guidelines, and report to the QA Committee on an ongoing basis.</p> <p>Date corrective actions completed; 12/7/2016</p>	12/7/16

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K 325	Continued From page 6 NFPA 101 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).		K 325		

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K 325	Continued From page 7 (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use		K 325		

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NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
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K 325	Continued From page 8 instructions each time a new refill is installed.		K 325	
K 353	<p>NFPA 101 Sprinkler System - Maintenance and SS=F Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 5, 2016 from approximately 10:00 AM to 3:30 PM, observation of the installed fire sprinkler pendants</p>		K 353	<p>K 353</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>32 residents, staff and visitors had the potential to be affected by this deficient practice. The five fire sprinkler pendants identified as being corroded have been ordered and will be replaced by Western States Fire Protection Company, Vic Wyatt (509-991-1232).</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken;</p> <p>All residents, staff and visitors had the potential to be affected by this deficient practice. The five fire sprinkler pendants identified as being corroded have been ordered and will be replaced by Western States Fire Protection Company, Vic Wyatt (509-991-1232).</p>

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K 353	Continued From page 9 revealed the following: Family Room across from Nurse's station: corroded pendant Storage room abutting Rooms 11 and 12: corroded pendant Oxygen storage room: corroded pendant Kitchen Dishwashing area: two (2) corroded pendants Actual NFPA standard: NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; The Maintenance Director or designee will ensure that during fire safety inspections sprinkler pendants are inspected. In addition, sprinkler pendant inspections will be added to the TEL system. How the corrective action with be monitored to ensure the deficient practice will not recur; The Maintenance Director or designee will ensure that during fire safety inspections sprinkler pendants are inspected. In addition, sprinkler pendant inspections will be added to the TEL system and Maintenance Director or designee will report to the QA Committee on an ongoing basis. Date corrective action completed; 12/7/2016	12/7/16
K 923	NFPA 101 Gas Equipment - Cylinder and	K 923		

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K 923 SS=E	<p>Continued From page 10</p> <p>Container Storage</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Standard is not met as evidenced by: Based on observation and interview, the facility</p>		K 923	<p>K 923</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>This deficient practice had the potential to affect all residents using oxygen within the facility. Designated areas were created for full and empty oxygen tank storage and staff was in-serviced on oxygen tank storage.</p> <p>How will other residents with the potential to be affected by this deficient practice be identified and what corrective actions will be taken;</p> <p>Only residents with physician's orders for oxygen therapy have the potential to be affected by this deficient practice. Designated areas were created for full and empty oxygen tank storage and staff was in-serviced on oxygen tank storage.</p> <p>What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur;</p> <p>Designated storage areas were created for full and empty oxygen bottles and staff in-serviced on proper oxygen tank storage.</p>	

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K 923	<p>Continued From page 11</p> <p>failed to ensure that medical gas cylinders were segregated while in storage. Failure to segregate full cylinders from empty cylinders could result in confusion and delay when replacing cylinders for residents requiring medical gases. This deficient practice affected residents in the facility receiving oxygen on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 5, 2016 from approximately 10:00 AM to 3:30 PM, observation of the oxygen storage room revealed oxygen cylinders in sizes "A", "C" and "E", intermingled together in storage racks, some with the valve protective caps and some without. Further observation revealed no labeling or other identifiers for full or empty cylinders.</p> <p>When asked how the facility knew which cylinders were empty and which were full, the Director of Nursing stated the cylinders without the caps were the empty cylinders.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 11 Gas Equipment</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p>		K 923	<p>How the corrective action will be monitored to ensure the deficient practice does not recur;</p> <p>Audits are being conducted of oxygen storage rooms to ensure proper oxygen tank storage. Results of the audits will be reported to the QA Committee on an ongoing basis.</p> <p>Date corrective action completed; 12/7/2016</p>	12/7/16

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K 923	Continued From page 12 11.6.5.2.1 When the facility employs cylinders with integral pressure gauge, it shall establish the threshold pressure at which a cylinder is considered empty. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923			